

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155656		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/09/2012	
NAME OF PROVIDER OR SUPPLIER  CANTERBURY NURSING AND REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 2827 NORTHGATE BLVD FORT WAYNE, IN 46835			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
F0000	<p>This visit was for the investigation of Complaint IN00103433.</p> <p>Complaint IN00103433-Substantiated. Federal/state deficiencies related to the allegations are cited at F 157, F279, F327, F328</p> <p>Unrelated deficiency is cited.</p> <p>Survey dates: February 7, 8, 9, 2012</p> <p>Facility number: 000275 Provider number: 155656 AIM number: 100290930</p> <p>Survey team: Ann Armey, RN</p> <p>Census bed type: SNF/NF: 103 Residential: 12 Total: 115</p> <p>Census payor type: Medicare: 13 Medicaid: 72 Other: 30 Total: 115</p> <p>Sample: 5</p>		F0000	<p>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. This Plan of Correction is prepared and/or executed solely because it is required by the provision of federal and state law. We respectfully request this Plan of Correction serve as our allegation of compliance effective March 6th, 2012.</p>			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/19/2012

FORM APPROVED

OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155656		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/09/2012	
NAME OF PROVIDER OR SUPPLIER  CANTERBURY NURSING AND REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 2827 NORTHGATE BLVD FORT WAYNE, IN 46835			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
	These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.  Quality review completed on February 14, 2012, by Bev Faulkner,RN .						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155656		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING		X3) DATE SURVEY COMPLETED 02/09/2012	
NAME OF PROVIDER OR SUPPLIER  CANTERBURY NURSING AND REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 2827 NORTHGATE BLVD FORT WAYNE, IN 46835			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
F0157 SS=D	<p>483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>Based on interview and record review, the facility failed to notify a resident's health care representative when there was a change in the resident's condition. This deficiency affected 1 of 5 residents</p>		F0157	<p>It is the policy of this facility to notify a resident's healthcare representative when there are changes in conditions. (1)Corrective Action for resident found to be affected by alleged</p>		03/06/2012	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155656		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING		X3) DATE SURVEY COMPLETED 02/09/2012	
NAME OF PROVIDER OR SUPPLIER  CANTERBURY NURSING AND REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 2827 NORTHGATE BLVD FORT WAYNE, IN 46835			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
	<p>reviewed for notification, in a sample of 5. (Resident #B)</p> <p>Findings include:</p> <p>The closed clinical record of Resident #B was reviewed on 2/7/12 at 2:30 p.m., and indicated the resident was admitted to the facility on 1/4/12 and was discharged to the hospital on 1/22/12.</p> <p>Resident #B's face sheet indicated the resident's primary contact was her son. The son was listed as the resident's Durable Power of Attorney, in a document signed by the resident, dated on 11/5/11 and notarized on 1/27/11. The Power of Attorney document granted fiduciary, financial and business powers to the son but did not specify that the son would have health care powers.</p> <p>A second document, in a file provided by the Administrator on 2/8/12, indicated the resident had appointed a daughter as her Health Care Representative on 10/13/11. The document was signed by the resident. and witnessed by another individual.</p> <p>The daughter, who was named as the Health Care Representative was not listed on the face sheet in the closed clinical record.</p>			<p>deficient practice: Resident B no longer resides at the facility.(2) Identification of other residents having potential to be affected by alleged deficient practice: A one time audit completed for current resident population to validate contact information, whether it is the resident themselves, or others, as designated at time of admission. Staff have been re-educated on the resident-family notification process in the event of a condition change.(3) Measures in place to ensure alleged deficient practice does not recur: The Charge nurses will be responsible to notify residents and families of condition changes as they occur. Charge nurses will be responsible to confirm the health care representative status at time of change in condition by visual validation of the resident's face sheet information. Documentation will be made in the resident's medical file to provide confirmation that the family member who is listed as the healthcare representative has been notified.. The face sheet information will be reviewed in person with the resident and/or their family member during the quarterly care plans.(4)How system will be monitored to ensure alleged deficient practice does not recur: The nurse managers/designee will be responsible to audit reported condition changes daily for 14</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155656		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING		X3) DATE SURVEY COMPLETED 02/09/2012	
NAME OF PROVIDER OR SUPPLIER  CANTERBURY NURSING AND REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 2827 NORTHGATE BLVD FORT WAYNE, IN 46835			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>On 1/19/12 at 11:00 a.m., the physician was notified about a decline in Resident #B's level of consciousness and increased confusion.</p> <p>On 1/19/12 at 2:15 p.m., nursing notes indicated the resident's son was aware of all new orders but there was no documentation the health care representative was notified about the resident's change of condition.</p> <p>Incident reports indicated the resident fell on 1/22/12, 1/21/12, 1/20/12 and 1/18/12. The incident reports indicated the son was notified regarding the falls but the daughter, who was the health care representative, was not notified.</p> <p>On 1/22/12 at 12:00 p.m. and 1/17/12 at 1:45 p.m., nursing notes indicated the resident had abnormal laboratory test results. The physician/nurse practitioner were notified, and the son was notified, but there is no documentation the health care representative was notified about the abnormal laboratory test results.</p> <p>On 2/7/12 at 4:00 p.m., LPN #10, who was the nurse on Resident B's hall, was interviewed and indicated she contacted the resident's son frequently and kept him updated on Resident #B's condition.</p> <p>On 2/8/12 at 12:00 p.m., the</p>		<p>days, the wkly for 8 weeks, and then 5 random reviews monthly for 6 months to ensure that appropriate notification has been made regarding the condition change. Any identified issues with non-compliance of notification per facility policy will be addressed through 1:1 education and/or disciplinary actions. Audit results will be reviewed monthly at CQI and will be discontinued after 6 months if there are no identified trends of non-compliance.</p>				

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/19/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155656		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING		X3) DATE SURVEY COMPLETED 02/09/2012	
NAME OF PROVIDER OR SUPPLIER  CANTERBURY NURSING AND REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 2827 NORTHGATE BLVD FORT WAYNE, IN 46835			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
	<p>Administrator indicated the son was designated as the primary contact because he was the Durable Power of Attorney. The Administrator indicated the Durable Power of Attorney document was dated 11/5/11, while the Health Care Representative document was dated 10/13/11, as a result, the Durable Power of Attorney's authority was felt to be the most current. The Administrator indicated typically the facility designates one person as a primary contact. The Administrator indicated the son accompanied the resident at the time of admission and filled out some of the admission paper work. Finally, the Administrator indicated the staff were never instructed by the son or Resident #B to call the resident's daughter regarding health care concerns.</p> <p>This Federal tag relates to Complaint IN00103433.</p> <p>3.1-5(a)(1) 3.1-5(a)(2) 3.1-5(a)(3)</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155656		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING		X3) DATE SURVEY COMPLETED 02/09/2012	
NAME OF PROVIDER OR SUPPLIER  CANTERBURY NURSING AND REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 2827 NORTHGATE BLVD FORT WAYNE, IN 46835			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
F0279 SS=D	<p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS</p> <p>A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>Based on interview and record review, the facility failed to develop an individualized care plan with interventions when a resident developed risk factors and signs of dehydration. This deficiency affected 1 of 3 residents who were reviewed for dehydration in a sample of 5. (Resident #B)</p> <p>Findings include:</p> <p>The closed clinical record of Resident # B was reviewed on 2/7/12 at 2:30 p.m., and indicated the resident had been admitted</p>		F0279	<p>It is the practice of this facility to develop individualized care plans with interventions when residents develop risk factors and signs of dehydration.(1) Corrective Action for alleged deficient practice: Resident B no longer resides at the facility.(2) Identification of other potential areas affected by alleged deficient practice: A one time audit has been completed for current resident population reviewing for any resident with diarrhea, nausea/vomiting or change in mental status. Should any resident be identified with the above symptoms, action(s) shall be taken to include MD/Family</p>		03/06/2012	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155656		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/09/2012	
NAME OF PROVIDER OR SUPPLIER  CANTERBURY NURSING AND REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 2827 NORTHGATE BLVD FORT WAYNE, IN 46835			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>to the facility from the hospital on 1/4/12, with diagnoses which included but were not limited to, chronic biventricular congestive heart failure, diabetes mellitus, seizure disorder, obesity and chronic renal insufficiency.</p> <p>The resident was discharged to the hospital on 1/22/12.</p> <p>Admission orders, dated 1/4/12, indicated the resident was to receive, among other medications:</p> <p>Spironolactone/Aldactone (a diuretic medication) 25 mg every day, Demadex (a diuretic medication) 40 mg twice daily and K-Dur (a potassium supplement) 40 mg every day.</p> <p>Dehydration was not identified as a trigger on the 1/11/12, RAI (Resident Assessment Instrument).</p> <p>On 1/16/12, the RD (Registered Dietician) assessed Resident #B's nutritional status. The RD's progress notes, dated 1/16/12, indicated, among other things, that the resident's estimated daily fluid needs were 3250 ccs to 3900 ccs.</p> <p>The RD note indicated the resident's diet and fluid at the bedside provided the resident's with her estimated fluid needs.</p>		<p>notification, change in plan of care, etc. The staff have been re-educated on the care planning process, which includes updating the care plans as condition changes arise, and implementation of new interventions as determined necessary based on interdisciplinary review and individual resident needs.</p> <p>(3)Systematic change to ensure alleged deficient practice does not recur: It is the responsibility of the Interdisciplinary Team to review and update the plans of care. Should a resident have a noted condition change with nausea, vomiting, diarrhea, and cognitive changes, said resident will be brought forward for the IDT review to assist with identification of new interventions to be implemented, resident/family notification and education, as well as MD notification. The Nurse Supervisors/designee will be responsible to review current resident population following a noted condition change of nausea and vomiting, diarrhea, and mental status changes daily for 14 days, wkly for 8 wks, and the 5 random reviews monthly for 6 months. In addition, the IDT team will review residents with noted diarrhea, nausea.vomiting, and/or mental status changes daily, Mon through Friday, for 60 days, wkly for 12 weeks, and then 5 random reviews monthly for 6 months to ensure new</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155656		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING		X3) DATE SURVEY COMPLETED 02/09/2012	
NAME OF PROVIDER OR SUPPLIER  CANTERBURY NURSING AND REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 2827 NORTHGATE BLVD FORT WAYNE, IN 46835			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
	<p>A nutritional care plan was initiated, on 1/16/12, and dehydration was not identified as an assessed problem but one of the nutritional goals was for the resident to be free of dehydration. The nutritional care plan interventions included the following: Provide diet as ordered Honor food preferences Monitor intake of meals and offer alternates as needed. Vitamins and minerals as ordered (multivitamin and potassium), Monitor weights, Encourage fluids unless contraindicated, and Monitor labs and monitor for signs and symptoms of hypo/hyperglycemia.</p> <p>On 1/17/12, a BMP (Basic Metabolic Panel) for Resident # B, indicated the resident had elevated potassium, BUN and creatinine levels as follows:: the potassium level was high at 5.4 (normal range 3.6-5.1), blood urea nitrogen level was high at 79 (normal range of 7-18) and the creatinine level was high at 3.0 (normal range of 0.6-1.3).</p> <p>On 1/17/12 at 1:45 p.m., nursing notes indicated, the Nurse Practitioner was notified about the abnormal laboratory results and the Demadex and K-Dur</p>			<p>interventions are identified and implemented for resident care. Any identified issue with non compliance in resident/family notification as per policy and procedure will result in 1:1 re-education and/or disciplinary action.(4) How Corrective Action of Alleged deficient practice will be monitored: The ADM/Designee will be responsible to review the results of the monitoring process and forward said reviews to the QA Committee for monthly review and discussion for 3 months and then quarterly review for 3 quarters. Any further action necessary will be as determined by the QA committee.Addendum for request on 3-6-12: A care plan will be implemented for residents who require use of a diuretic at the time the order is recieved by the charge nurse</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155656		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING		X3) DATE SURVEY COMPLETED 02/09/2012	
NAME OF PROVIDER OR SUPPLIER  CANTERBURY NURSING AND REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 2827 NORTHGATE BLVD FORT WAYNE, IN 46835			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE		
	<p>dosages were reduced.</p> <p>Physician orders, dated 1/17/12, indicated the potassium was reduced to 30 mgms every day and the Demadex was reduced to 30 mgms twice daily.</p> <p>A repeat BMP laboratory test was ordered to be done in a week.</p> <p>On 1/18/12 at 2:20 p.m., nursing notes indicated the resident had one loose stool and an episode of dry heaves.</p> <p>On 1/19/12 at 11:00 a.m., a SBAR physician/nurse practitioner communication and progress note indicated the resident's condition had a changed since 1/17/12 and she was experiencing increased confusion, an unsteady gait, and a decrease in the level of consciousness.</p> <p>On 1/19/12, the Physician ordered a urinalysis, Phenergan as needed for nausea and Immodium as needed for diarrhea.</p> <p>On 1/20/12 at 10:00 p.m., nursing notes indicated the resident had a small loose stool and a fall with no injury.</p> <p>On 1/21/12 at 9:50 a.m., the resident had one "episode of diarrhea" and Immodium was given. The note indicated they were unable to obtain the urine specimen</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155656		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING		X3) DATE SURVEY COMPLETED 02/09/2012	
NAME OF PROVIDER OR SUPPLIER  CANTERBURY NURSING AND REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 2827 NORTHGATE BLVD FORT WAYNE, IN 46835			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE		
	<p>because the urine was contaminated with stool.</p> <p>On 1/22/12 at 12:00 p.m., nursing notes indicated intravenous fluids were ordered but after three attempts staff were unable to obtain access. The resident's son was notified about the order for intravenous fluids but indicated to be careful because the resident experienced fluid overload in the intensive care unit.</p> <p>The note indicated a urine specimen was obtained by straight catheterization and only "1 vial obtained."</p> <p>The note further indicated the Nurse Practitioner was notified regarding critical laboratory test results and ordered the resident to be transported to the emergency room.</p> <p>The BMP (Basic Metabolic Panel) laboratory report, dated 1/22/11, indicated Resident B's: potassium level was "panic high" at 6.6 (normal range 3.6-5.1), blood urea nitrogen level was "panic high" at 117 (normal range of 7-18) and the creatinine level was high at 7.2 (normal range of 0.6-1.3).</p> <p>The facility transfer form, dated 1/22/12 (no time listed) indicated the resident had loose stools for three days, a decreased level of consciousness, and critical</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155656		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING		X3) DATE SURVEY COMPLETED 02/09/2012	
NAME OF PROVIDER OR SUPPLIER  CANTERBURY NURSING AND REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 2827 NORTHGATE BLVD FORT WAYNE, IN 46835			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE		
	<p>laboratory test results.</p> <p>Hospital emergency room records, dated 1/22/12, indicated the resident had a cardiac arrest enroute to the emergency room and was pulseless and apneic upon arrival at the emergency room. The record indicated the resident was intubated and had a spontaneous return of circulation. The note further indicate "I suspect that she has become dehydrated which has placed her into acute renal failure and hyperkalemia as the cause of her dysrhythmia..."</p> <p>A hospital consultation report, dated 1/22/12, indicated Resident #B had the following: "1. Acute kidney injury and hyperkalemia secondary to a combination of volume depletion from diarrhea and concomitant use of diuretic therapy, including aldactone."</p> <p>Although the resident had the following signs of dehydration; acute confusion, change in mental status, elevated laboratory values and low urine output, there was no documentation a comprehensive care plan specific to hydration or the prevention of dehydration was developed.</p> <p>On 2/9/12 at 10:30 a.m., the DON</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155656		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING		X3) DATE SURVEY COMPLETED 02/09/2012	
NAME OF PROVIDER OR SUPPLIER  CANTERBURY NURSING AND REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 2827 NORTHGATE BLVD FORT WAYNE, IN 46835			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE		
	<p>(Director of Nursing) was interviewed. The DON indicated a specific care plan for hydration/dehydration was not developed and the nutritional careplan was not updated. The DON indicated they continued with the exiting nutritional interventions previously care planned and the physician or nurse practitioner were notified when the resident experienced changes and orders were obtained to address each concern.</p> <p>The policy for the nutrition and hydration program, effective 4/2010, provided by the DON, was reviewed on 2/9/12 at 10:00 a.m., and indicated "...Monitor the resident for factors that put the resident at risk of dehydration. These may include but are not limited to:...</p> <p>Diarrhea Diuretic medications... Renal disease...</p> <p>b.) If new risk factors are identified, new interventions will be implemented and appropriate clinicians will be notified for further assessments...</p> <p>5. Assess for clinical sign/symptoms of insufficient fluid intake including, but not limited to:</p> <p>Acute confusion Change in mental status... Deteriorated cognitive status... Elevated laboratory values... Low urine output...</p>						

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/19/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155656		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/09/2012	
NAME OF PROVIDER OR SUPPLIER  CANTERBURY NURSING AND REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 2827 NORTHGATE BLVD FORT WAYNE, IN 46835			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
	<p>7. Implement individualized interventions based on resident needs..."</p> <p>This Federal tag relates to Complaint IN00103433.</p> <p>3.1-35(a)</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155656		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/09/2012	
NAME OF PROVIDER OR SUPPLIER  CANTERBURY NURSING AND REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 2827 NORTHGATE BLVD FORT WAYNE, IN 46835			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
F0327 SS=D	<p>483.25(j) SUFFICIENT FLUID TO MAINTAIN HYDRATION The facility must provide each resident with sufficient fluid intake to maintain proper hydration and health.</p> <p>Based on interview, and record review, the facility failed to re-assess and develop individualized care plan interventions when a resident developed risk factors and signs of dehydration. This deficiency affected 1 of 3 residents who were reviewed for dehydration in a sample of 5. (Resident #B)</p> <p>Findings include:</p> <p>The closed clinical record of Resident # B was reviewed on 2/7/12 at 2:30 p.m., and indicated the resident had been admitted to the facility from the hospital on 1/4/12, with diagnoses which included but were not limited to, chronic biventricular congestive heart failure, diabetes mellitus, seizure disorder, obesity and chronic renal insufficiency.</p> <p>The resident was discharged to the hospital on 1/22/12.</p> <p>Admission orders, dated 1/4/12, indicated the resident was to receive, among other medications: Spironolactone/Aldactone (a diuretic medication) 25 mg every day, Demadex (a diuretic medication) 40 mg</p>		F0327	<p>It is the facility's policy to assess and develop individualized care plan interventions when a resident develops risk factors and signs of dehydration.(1) Corrective Action: Resident b no longer resides at the center(2) Identification of Other residents with potential to be affected by alleged deficient practice: A one time audit has been completed for current resident population reviewing for any residents with diarrhea, nausea/vomiting, or change in mental status. Any identified symptoms will be reported to the attending physician and notification will be made to the appropriate healthcare representative on record. Care plans will be updated to reflect the change in condition.(3) Systematic change to ensure that alleged deficient practice does not recur: The staff were re-educated ont he care planning process. which includes updating the care plans as condition changes arise, and implementation of new interventions as determined necessary based on interdisciplinary review and individual resident needs. It is the responsibility of the IDT team to review and update the plans of</p>		03/06/2012	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155656		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/09/2012	
NAME OF PROVIDER OR SUPPLIER  CANTERBURY NURSING AND REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 2827 NORTHGATE BLVD FORT WAYNE, IN 46835			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
	<p>twice daily and K-Dur (a potassium supplement) 40 mg every day.</p> <p>The nursing comprehensive data collection and assessment form, dated 1/4/12, indicated Resident #B was alert and oriented. The form indicated the resident's oral mucosa was pink and moist.</p> <p>On 1/5/12, the baseline BMP (Basic Metabolic Panel) laboratory report for Resident #B, indicated the following: the potassium level was 3.8 (normal range 3.6-5.1), blood urea nitrogen level was high at 41 (normal range of 7-18) and the creatinine level was high at 1.9 (normal range of 0.6-1.3).</p> <p>On 1/6/12 at 1:00 p.m., and on 1/12/12 at 9:45 a.m., nursing notes indicated Resident #B was having periods of confusion.</p> <p>Dehydration was not identified as a trigger on the 1/11/12, RAI (Resident Assessment Instrument).</p> <p>On 1/16/12, the RD (Registered Dietician) assessed Resident #B's nutritional status. The RD's progress notes, dated 1/16/12, indicated, among</p>			<p>care, Should a resident have a noted condition change with nausea, vomiting, diarrhea, and cognitive changes, said resident will be brought forward for the IDT review to assist with identification of new interventions to be implemented, resident/family notification and education, as well as MD notification.(4) Monitor of systematic change to ensure alleged deficient practice does not recur: The Nurse managers/designee will be responsible to review current resident population following a noted condition change of nausea and vomiting, diarrhea, and mental status daily for 14 days weekly for 8 wks, and then 5 random reviews monthly for 6 months. In addition, the IDT team will review residents with noted diarrhea, nausea/vomiting, and/or mental status changes daily Mon thru Fri for 60 days, weekly for 12 wks, and then 5 random reviews monthly for 6 months to ensure new interventions are identified and implemented for resident care. Any identified issue with non-compliance in resident/family notification as per policy and procedure will result in 1:1 re-education and/or disciplinary action. The ADM/Designee will be responsible to review the results of the monitoring process and forward said reviews to the CQI committee for monthly review for 3 quarters. Any further action</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155656		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/09/2012	
NAME OF PROVIDER OR SUPPLIER  CANTERBURY NURSING AND REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 2827 NORTHGATE BLVD FORT WAYNE, IN 46835			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
	<p>other things, that the resident's estimated daily fluid needs were 3250 ccs to 3900 ccs.</p> <p>The RD note indicated the resident's diet and fluid at the bedside provided the resident's with her estimated fluid needs.</p> <p>A nutritional care plan was initiated, on 1/16/12, and dehydration was not identified as an assessed problem but one of the nutritional goals was for the resident to be free of dehydration.</p> <p>The nutritional care plan interventions included the following: Provide diet as ordered Honor food preferences Monitor intake of meals and offer alternates as needed. Vitamins and minerals as ordered (multivitamin and potassium), Monitor weights, Encourage fluids unless contraindicated, and Monitor labs and monitor for signs and symptoms of hypo/hyperglycemia.</p> <p>On 1/17/12, a second BMP (Basic Metabolic Panel) for Resident # B, indicated the resident had elevated potassium, BUN and creatinine levels as follows:: the potassium level was high at 5.4 (normal range 3.6-5.1), blood urea nitrogen level was high at 79</p>			<p>necessary will be determined by the CQI committee.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155656		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/09/2012	
NAME OF PROVIDER OR SUPPLIER  CANTERBURY NURSING AND REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 2827 NORTHGATE BLVD FORT WAYNE, IN 46835			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE		
	<p>(normal range of 7-18) and the creatinine level was high at 3.0 (normal range of 0.6-1.3).</p> <p>On 1/17/12 at 1:45 p.m., nursing notes indicated, the Nurse Practitioner was notified about the abnormal laboratory results and the Demadex and K-Dur dosages were reduced.</p> <p>Physician orders, dated 1/17/12, indicated the potassium was reduced to 30 mgms every day and the Demadex was reduced to 30 mgms twice daily. A repeat BMP laboratory test was ordered to be done in a week.</p> <p>On 1/18/12 at 2:20 p.m., nursing notes indicated the resident had one loose stool and an episode of dry heaves.</p> <p>On 1/19/12 at 11:00 a SBAR physician/nurse practitioner communication and progress note indicated the resident's condition had a changed since 1/17/12 and she was experiencing increased confusion, an unsteady gait, and a decrease in the level of consciousness.</p> <p>On 1/19/12, the Physician ordered a urinalysis, Phenergan as needed for nausea and Immodium as needed for diarrhea.</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155656		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/09/2012	
NAME OF PROVIDER OR SUPPLIER  CANTERBURY NURSING AND REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 2827 NORTHGATE BLVD FORT WAYNE, IN 46835			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
	<p>In addition, the resident's orthostatic pulse and blood pressure were to be checked every shift for 72 hours and the oxygen saturation rates were to be checked every 2 hours between 10:00 p.m. and 6:00 a.m.</p> <p>On 1/19/12 at 10:00 p.m., the nursing note indicated the resident returned to her room before eating and stated "I was too sick to stay." She was given Phenergan which was effective. The note indicated fluids were encouraged but taken poorly. The note further indicated "...Unable to obtain UA (urinalysis)-1st spec (specimen) clean but not enough urine 2nd spec (specimen) contam c BM (contaminated with bowel movement)..."</p> <p>On 1/20/12 at 10:00 p.m., nursing notes indicated the resident had a small loose stool and a fall with no injury.</p> <p>On 1/21/12 at 9:50 a.m., the resident had one "episode of diarrhea" and Immodium was given. The note indicated they were unable to obtain the urine specimen because the urine was contaminated with stool.</p> <p>Care tracker fluid Intake records between 1/17/12 and 1/22/12 indicated the resident's daily average fluid intake was 1255 cc.</p> <p>Care tracker bowel reports between</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155656		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/09/2012	
NAME OF PROVIDER OR SUPPLIER  CANTERBURY NURSING AND REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 2827 NORTHGATE BLVD FORT WAYNE, IN 46835			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>1/17/12 and 1/22/12 indicated the resident had two watery diarrhea stools on 1/19/12 and 1/21/12 respectively, while nursing notes indicated the resident had one loose stool on 1/18/12 and one loose stools on 1/20/11 for a total of four loose stools recorded in six days.</p> <p>On 1/22/12 at 12:00 p.m., nursing notes indicated intravenous fluid were ordered but after three attempts staff were unable to obtain access. The resident's son was notified about the order for intravenous fluids but indicated to be careful because the resident experienced fluid overload in the intensive care unit.</p> <p>The note indicated a urine specimen was obtained by straight catheterization and only "1 vial obtained."</p> <p>The note further indicated the Nurse Practitioner was notified regarding critical laboratory test results and ordered the resident to be transported to the emergency room.</p> <p>The BMP (Basic Metabolic Panel) laboratory report, dated 1/22/12, indicated Resident B's: potassium level was "panic high" at 6.6 (normal range 3.6-5.1), blood urea nitrogen level was "panic high" at 117 (normal range of 7-18) and the creatinine level was high at 7.2 (normal range of 0.6-1.3).</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155656		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING		X3) DATE SURVEY COMPLETED 02/09/2012	
NAME OF PROVIDER OR SUPPLIER  CANTERBURY NURSING AND REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 2827 NORTHGATE BLVD FORT WAYNE, IN 46835			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE		
	<p>The facility transfer form, dated 1/22/12 (no time listed) indicated the resident had loose stools for three days, a decreased level of consciousness, and critical laboratory test results.</p> <p>Hospital emergency room records, dated 1/22/12, indicated the resident had a cardiac arrest enroute to the emergency room and was pulseless and apneic upon arrival at the emergency room. The record indicated the resident was intubated and had a spontaneous return of circulation. The note further indicate "I suspect that she has become dehydrated which has placed her into acute renal failure and hyperkalemia as the cause of her dysrhythmia..."</p> <p>A hospital consultation report, dated 1/22/12, indicated Resident #B had the following: "1. Acute kidney injury and hyperkalemia secondary to a combination of volume depletion from diarrhea and concomitant use of diuretic therapy, including aldactone."</p> <p>There was no documentation the resident's dehydration risks were reassessed when she developed diarrhea along with her preexisting risk factors of renal disease and diuretic therapy. In</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155656		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING		X3) DATE SURVEY COMPLETED 02/09/2012	
NAME OF PROVIDER OR SUPPLIER  CANTERBURY NURSING AND REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 2827 NORTHGATE BLVD FORT WAYNE, IN 46835			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE		
	<p>addition, although the resident had the following signs of dehydration; acute confusion, change in mental status, elevated laboratory values and low urine output, there was no documentation a comprehensive care plan specific to hydration or the prevention of dehydration was developed.</p> <p>On 2/9/12 at 10:30 a.m., the DON (Director of Nursing) was interviewed. The DON indicated a specific care plan for hydration/dehydration was not developed and the nutritional careplan was not updated. The DON indicated they continued with the exiting nutritional interventions previously care planned and the physician or nurse practitioner were notified when the resident experienced changes and orders were obtained to address each concern.</p> <p>The policy for the nutrition and hydration program, effective 4/2010, provided by the DON, was reviewed on 2/9/12 at 10:00 a.m., and indicated "...Monitor the resident for factors that put the resident at risk of dehydration. These may include but are not limited to:...</p> <p>Diarrhea Diuretic medications... Renal disease...</p> <p>b.) If new risk factors are identified, new interventions will be implemented and</p>						

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/19/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155656		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/09/2012	
NAME OF PROVIDER OR SUPPLIER  CANTERBURY NURSING AND REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 2827 NORTHGATE BLVD FORT WAYNE, IN 46835			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
	<p>appropriate clinicians will be notified for further assessments...</p> <p>5. Assess for clinical sign/symptoms of insufficient fluid intake including, but not limited to: Acute confusion Change in mental status... Deteriorated cognitive status... Elevated laboratory values... Low urine output...</p> <p>7. Implement individualized interventions based on resident needs..."</p> <p>This Federal tag relates to Complaint IN00103433.</p> <p>3.1-46(b)</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155656		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING		X3) DATE SURVEY COMPLETED 02/09/2012	
NAME OF PROVIDER OR SUPPLIER  CANTERBURY NURSING AND REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 2827 NORTHGATE BLVD FORT WAYNE, IN 46835			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
F0328 SS=D	<p>483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses.</p> <p>Based on observation, interview, and record review, the facility failed to ensure PAP (Positive Airway Pressure) ventilation was provided as ordered for 2 of 3 resident, who had orders for positive airway pressure ventilation, in a sample of 5. (Resident #C and Resident #B)</p> <p>Findings include:</p> <p>On 2/7/12 at 11:00 a.m., LPN #10 indicated Resident #C was interviewable and used a C-PAP (Continuous Positive Airway Pressure) machine.</p> <p>On 2/7/12 at 11:15 a.m., Resident #C was interviewed. Resident #C indicated she hadn't been using her C-PAP machine because the machine had been broken for several months. She indicated she contacted the company, where she obtained the machine, but they told her as long as she was residing in the nursing</p>		F0328	<p>It is the practice of this facility to ensure that residents receive proper treatment and care for special services.(1)Corrective Action for alleged deficient practice: Resident C currently has and is using a c-pap machine under the direction of physician orders. Resident B no longer resides at the center.(2) Identification of others that have potential to be affected by alleged deficient practice: A one-time audit has been completed to review residents with Bi-Pap and C-Pap orders, The Licensed Supervisory staff have been re-educated on providing Bi-Pap and C-Pap as per MD order, and policy and procedure.(3) Systematic change to ensure alleged deficient practice does not recur: It is the responsibility of the Licensed Supervisory Nurse to ensure Bi-Pap and C-Pap treatments are completed as per MD order. The nurse supervisors/designee will be responsible to review the</p>		03/06/2012	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155656		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING		X3) DATE SURVEY COMPLETED 02/09/2012	
NAME OF PROVIDER OR SUPPLIER  CANTERBURY NURSING AND REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 2827 NORTHGATE BLVD FORT WAYNE, IN 46835			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>home they were not responsible for fixing the machine. The resident indicated she did not like using the machine but she felt she needed to use it.</p> <p>On 2/7/12 at 11:30 a.m., the DON (Director of Nursing) indicated she was not aware Resident #C's C-PAP machine was broken.</p> <p>On 2/7/12 at 11:40 a.m., accompanied by the ADON (Assistant Director of Nursing) and the Administrator, the C-PAP machine in Resident #C's room was observed. The surface of the machine was dusty, and an oxygen adaptor was missing from the humidifier on the machine. The resident, who was in the room when the C-PAP machine was checked, indicated the mask was also missing.</p> <p>The Administrator indicated a respiratory therapy company would be notified and would deliver and set up a C-PAP machine for the resident.</p> <p>The clinical record of Resident #C was reviewed and indicated the resident was admitted to the facility on 3/2/11 with diagnoses which included but were not limited to, diabetes mellitus, chronic obstructive pulmonary disease, sleep apnea and obesity.</p>		<p>provision of Bi-Pap and C-Pap device care and application daily for 14 days, wkly for 8 wks, and then 5 random reviews monthly for 6 months. Any identified issue with non-compliance in resident/family notification as per policy and procedure will result in 1:1 re-education and/or disciplinary action.(4) The DON/Designee will be responsible to review the results of the monitoring process and forward said reviews to the QA Committee for monthly review and discussion for 3 months, and then quarterly for 3 quarters. Any further action necessary will be as determined by the QA committee.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155656		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING		X3) DATE SURVEY COMPLETED 02/09/2012	
NAME OF PROVIDER OR SUPPLIER  CANTERBURY NURSING AND REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 2827 NORTHGATE BLVD FORT WAYNE, IN 46835			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE		
	<p>Nursing notes, dated 1/11/12 at 9:30 p.m., indicated the resident was transported to a behavioral health unit.</p> <p>An Internal Medicine Consultation, dated 1/12/12, indicated Resident #C had "Chronic Obstructive Sleep Apnea Syndrome. CPAP broken-out pt (patient) f/u (follow-up) NH MD (Nursing Home Medical Doctor)..."</p> <p>Nursing notes, dated 1/17/12 at 8:45 p.m., indicated the resident was readmitted to the facility from the hospital.</p> <p>Readmission orders, dated 1/17/12, indicated the resident was to receive "C-PAP @ (at) 16 cm H2O @ HS (Hour of Sleep) c (with) 1 L O2 (one liter of oxygen)."</p> <p>The January 2012, MAR (Medication Administration Record) indicated the C-PAP readmission orders were noted but were circled as not provided between 1/18-31/12. There was no explanation on the MAR/TAR or in the nursing notes regarding why the CPAP ventilation had not been provided.</p> <p>The February 2012 MAR indicated the C-PAP ventilation was circled as not provided on 2/1-3/12 and was initialed as provided on 2/4-7/12.</p> <p>On 2/8/12 at 9:15 a.m., LPN #11, who had initialed Resident #C had received the</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155656		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING		X3) DATE SURVEY COMPLETED 02/09/2012	
NAME OF PROVIDER OR SUPPLIER  CANTERBURY NURSING AND REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 2827 NORTHGATE BLVD FORT WAYNE, IN 46835			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE		
	<p>C-PAP ventilation on 2/5-7/2012, was interviewed.</p> <p>LPN #11 indicated the resident did not use the C-PAP machine on 2/5-7/12 and she forgot to circle the entry. She indicated last summer the resident's C-PAP machine was in the room but she hadn't seen it recently. LPN #11 indicated she thought the resident's son took the machine because it needed to be fixed.</p> <p>On 2/7/12 at 1:30 p.m., CRT (Certified Respiratory Therapist) #13, indicated she had given Resident #C a C-PAP machine. The CRT indicated it was important for the resident to use the machine, when she was sleeping because Resident #C was at high risk of spontaneous airway obstruction or apnea.</p> <p>2. On 2/7/12 at 11:00 a.m., LPN #10 indicated a recently discharged resident, Resident #B, had received BI-PAP ventilation at night when she was in the facility.</p> <p>The closed clinical record of Resident #B was reviewed on 2/7/12 at 2:30 p.m., and indicated the resident was admitted to the facility from the hospital on 1/4/12, with diagnoses which included but were not limited to, chronic biventricular congestive heart failure, and obstructive</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155656		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/09/2012	
NAME OF PROVIDER OR SUPPLIER  CANTERBURY NURSING AND REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 2827 NORTHGATE BLVD FORT WAYNE, IN 46835			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE		
	<p>sleep apnea.</p> <p>The Hospital discharge summary, dated 1/4/12, indicated the resident received Bilevel Positive Airway Pressure (BIPAP) with supplemental oxygen in the hospital.</p> <p>Hospital admission orders, dated 1/4/12, indicated CPAP + O2 (Continuous positive airway pressure plus oxygen).</p> <p>The order for the CPAP was not noted on the 1/4/12, admission POS (Physician Order Sheet) or on the January 2012 MAR/TAR (Medication/Treatment Administration Records) . There was no documentation on the MAR/TAR to indicate the C-PAP ventilation was initiated until 1/10/12 (6 days after admission).</p> <p>On 1/4/12 at 8:00 p.m., nursing notes indicated the resident's lung sound were diminished and she stated she could not lay down flat in bed, could not breathe and could not tolerate the CPAP at the Hospital.</p> <p>On 1/6/12, Nurse Practitioner notes indicated the resident had difficulty sleeping and was not on the BiPAP-"unable to tolerate."</p> <p>There was no documentation the CPAP</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155656		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING		X3) DATE SURVEY COMPLETED 02/09/2012	
NAME OF PROVIDER OR SUPPLIER  CANTERBURY NURSING AND REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 2827 NORTHGATE BLVD FORT WAYNE, IN 46835			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE		
	<p>orders from the hospital were discontinued or that attempts were made to clarify the CPAP orders (to obtain the pressure settings and oxygen flow rates) or that a CPAP machine was set-up or obtained at the time of admission.</p> <p>On 1/9/12 at 10:00 p.m. (4 days after admission), nursing notes indicated, "...Attempted x 3 to obtain CPAP orders..."</p> <p>On 1/10/12 at 2:40 p.m., nursing notes indicated the physician called with the pressure setting for a BIPAP (Bilevel Positive Air Pressure) machine and "...resp (respiratory) to be out c (with) machine."</p> <p>Physician orders, dated 1/10/12, indicated "Bipap to be worn at HS (Hour of Sleep) c (with) settings - 10/4."</p> <p>On 1/10/12 at 10:00 p.m., nursing notes indicated the BIPAP machine was delivered and was on while the resident was sleeping.</p> <p>On 1/11/12, physician's order indicated, "...May use Bi-pap c (with) 3 l O2 (three liters of oxygen)..."</p> <p>On 2/7/12 at 4:00 p.m., LPN #10 was interviewed. LPN #10 indicated a family member came in to the facility a few days</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155656		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING		X3) DATE SURVEY COMPLETED 02/09/2012	
NAME OF PROVIDER OR SUPPLIER  CANTERBURY NURSING AND REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 2827 NORTHGATE BLVD FORT WAYNE, IN 46835			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE		
	<p>after Resident #B's admission and noticed a (PAP) machine was not in the room. The family member told her it was "essential" that the resident use the machine at night and they needed to call the hospital pulmonologist to get the settings.</p> <p>On 2/8/12 at 3:30 p.m., RN #12, who admitted Resident #B on 1/4/12, was interviewed. RN #12 indicated she called the respiratory therapy company after Resident #B was admitted and they indicated she needed to get the (PAP) settings before they could bring a machine. She indicated Resident #B said she would not wear the CPAP machine so she did not follow-up and obtain clarification orders. She indicated she received a disciplinary action for the not following up on the CPAP orders on 1/13/12.</p> <p>The policy for Non-Invasive ventilation (Continuous Positive Airway Pressure/Bilevel Positive Airway Pressure, revised 1/2009, provided by the DON, was reviewed on 2/8/12 at 4:30 p.m., and indicated "Respiratory Therapist and/or nursing personnel trained to perform and care for the CPAP/BiPAP dependent resident will perform equipment setup, monitoring, and troubleshooting as per physician's order...</p>						

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/19/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155656		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/09/2012	
NAME OF PROVIDER OR SUPPLIER  CANTERBURY NURSING AND REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 2827 NORTHGATE BLVD FORT WAYNE, IN 46835			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
	<p>Verify physician's order including: amount of pressure and duration of use Amount of supplemental oxygen... Mask size..."</p> <p>This Federal tag relates to Complaint IN00103433.</p> <p>3.1-47(a)(6)</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155656		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING		X3) DATE SURVEY COMPLETED 02/09/2012	
NAME OF PROVIDER OR SUPPLIER  CANTERBURY NURSING AND REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 2827 NORTHGATE BLVD FORT WAYNE, IN 46835			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
F0514 SS=D	<p>483.75(l)(1) RES RECORDS-COMplete/ACCURATE/ACCE SSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>Based on observation, interview, and record review, the facility failed to follow their policy to circle omitted treatments and document the reason for the omission. This deficiency affected 1 of 5 resident, whose treatments were reviewed, in a sample of 5. (Resident #C)</p> <p>Findings include:</p> <p>On 2/7/12 at 11:15 a.m., Resident #C was interviewed. Resident #C indicated she hadn't been using her C-PAP machine because the machine had been broken for several months.</p> <p>On 2/7/12 at 11:30 a.m., the DON (Director of Nursing) indicated she was not aware Resident #C's C-PAP machine was broken.</p>		F0514	<p>It is the policy of this facility to circle omitted treatments and document the reason for the omission.(1) Corrective action taken for resident affected by alleged deficient practice: A audit was completed to ensure circled medications or treatments have been addressed to ensure policy and procedure has been followed for documenting the reason for any omissions.(2) Identification of other residents to have potential to be affected by alleged deficient practice: A one time audit was completed on current resident population to ensure circled medications or treatments have been addressed to ensure policy and procedure have been followed for documenting the reason for an omission.(3) Systematic Change to ensure alleged deficient practice does not recur: Staff have received re-education</p>		03/06/2012	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155656		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING		X3) DATE SURVEY COMPLETED 02/09/2012	
NAME OF PROVIDER OR SUPPLIER  CANTERBURY NURSING AND REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 2827 NORTHGATE BLVD FORT WAYNE, IN 46835			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>On 2/7/12 at 11:40 a.m., accompanied by the ADON (Assistant Director of Nursing) and the Administrator, the C-PAP machine in Resident #C's room was observed. The surface of the machine was dusty, and an oxygen adaptor was missing from the humidifier on the machine. The resident, who was in the room when the C-PAP machine was checked, indicated the mask was also missing.</p> <p>The clinical record of Resident #C was reviewed on 2/9/12 at 11:45 a.m., and indicated the resident was admitted to the facility on 3/2/11, with diagnoses which included but were not limited to, diabetes mellitus, chronic obstructive pulmonary and sleep apnea.</p> <p>The resident was readmitted to the facility from the hospital on 1/17/12.</p> <p>Readmission orders, dated 1/17/12, indicated the resident was to receive "C-PAP @ (at) 16 cm H2O @ HS (Hour of Sleep) c (with) 1 L O2 (one liter of oxygen).</p> <p>The January 2012, MAR (Medication Administration Record) indicated the C-PAP readmission orders were noted but were circled as not provided between 1/18-31/12. There was no explanation for</p>		<p>regarding the policy/procedures for documenting omission of medication or treatments. The nurse managers are responsible to review the medication and treatment records daily for 14 days, wkly for 8 wks, and then 5 random reviews monthly for 6 months. Any identified issue with non-compliance will result in 1:1 education and/or disciplinary actions.(4)Monitoring of Systematic Change to ensure alleged deficient practice does not recur: The DON/designee will monitor the results of the daily audits and forward the information to the CQI committee for discussion monthly for 3 months and then quarterly for 3 quarters. Any further action necessary will be as determined by the CQI committee.</p>				

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/19/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155656		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING		X3) DATE SURVEY COMPLETED 02/09/2012	
NAME OF PROVIDER OR SUPPLIER  CANTERBURY NURSING AND REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 2827 NORTHGATE BLVD FORT WAYNE, IN 46835			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>why the C-PAP ventilation was not provided on the MAR or TAR (Medication/Treatment Administration Records) or in the nursing notes. The February 2012 MAR indicated the C-PAP ventilation was circled as not provided on 2/1-3/12 and was initialed as provided on 2/4-7/12.</p> <p>On 2/8/12 at 9:15 a.m., LPN #11, who had initialed Resident #C had received the C-PAP ventilation on 2/5-7/2012, was interviewed. LPN #11 indicated the resident did not use the C-PAP machine on 2/5-7/12 and she forgot to circle the entry.</p> <p>On 2/7/12 at 11:15 a.m., during an interview with Resident #C, two rolled ace bandages were observed on top of her walker. Resident #C was sitting on the edge of her bed, and she had no ace wrap on her legs. She had a quarter sized red area on her left lower leg.</p> <p>The February, 2012 TAR (Treatment Administration Record) was reviewed on 2/7/12 at 11:30 a.m., and indicated the resident was to have ace elastic bandage wrap as directed "Toes to Knees-May Have Off at HS (Hours Sleep) on daily. The TAR indicated the Ace wraps had been applied on 2/7/12. The TAR indicated the Resident #C was to have a</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155656		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING		X3) DATE SURVEY COMPLETED 02/09/2012	
NAME OF PROVIDER OR SUPPLIER  CANTERBURY NURSING AND REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 2827 NORTHGATE BLVD FORT WAYNE, IN 46835			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE		
	<p>Xeroform dressing applied daily to a blister on left leg. The Xeroform dressing was signed as done on 2/7/12.</p> <p>On 2/7/12 at 11:45 a.m., the DON (Director of Nursing) was interviewed and indicated the ace wrap had not been on when she checked the resident at 8:00 a.m. on 2/7/12. She indicated the treatment was scheduled to be done on the night shift and she would check with the night nurse, to see if the treatments had been done.</p> <p>On 2/8/12 at 9:15 a.m., LPN #11, who had signed that Resident #C's treatment and ace wrap had been done on 2/7/11, was interviewed. LPN #11 indicated on 2/7/12, during the early morning, the resident did not feel well so she did not do the treatment or ace wrap. She indicated she had signed that the treatments were done earlier and forgot to circle the treatments on the TAR when she did not do them.</p> <p>The skin sheet indicated on 2/7/12, the area on the left leg was stage II, 3 cm by 3 cm, was "essentially healed" but the treatment was to continue.</p> <p>The procedure for medication administration, revised 7/2010, provided by the DON (Director of Nursing), was</p>						

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/19/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155656		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/09/2012	
NAME OF PROVIDER OR SUPPLIER  CANTERBURY NURSING AND REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 2827 NORTHGATE BLVD FORT WAYNE, IN 46835			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE		
	<p>reviewed on 2/8/12 at and indicated "...Document the following as applicable: a. Administration of medication on the MAR (Medication Administration Record) as soon as medications are given. b. Indicate refused or omitted dose by circling your initials in the appropriate block.. c. Indicate the reason for omission on the nursing progress notes or on the back of the MAR."</p> <p>On 2/9/12 at 10:00 a.m., the DON indicated the facility did not have a separate procedure for the administration of treatments and the policy for Medication Administration applied to treatment administration as well.</p> <p>3.1-50(a)(1)</p>						